Critical Incident Rapid Response Team

[redacted]

Florida Department of Children and Families
April 3, 2017

Critical Incident Rapid Response Team

[redacted]
Southeast Region
Circuit 15
Palm Beach County, Florida
2017-054129

Table of Contents

Executive Summary

On March 2, 2017, the department received notification that 11-month-old [redacted] was removed from life support and officially pronounced deceased eight days after he was found to be in distress by his non-relative caregiver, 39-year-old [redacted].

On February 21, 2017, [redacted] found [redacted] breathing and whimpering in his crib with a blanket wrapped around his neck. As a result, 9-1-1 was called and [redacted] was transported to a local hospital. Due to the critical nature of his condition, [redacted] was transferred via helicopter to another hospital better equipped to meet his needs. Over the course of the next several days, [redacted] condition continued to deteriorate and he was subsequently determined to have no brain activity. Following organ procurement on March 1, 2017, [redacted] was officially pronounced deceased. The cause of death is currently unknown and autopsy results are still pending.

Because there was a verified prior report involving the family that occurred within 12 months of [redacted] death, DCF Secretary Mike Carroll deployed a Critical Incident Rapid Response Team (CIRRT) to Palm Beach County to review the prior interventions with the family and to assess for any potential systemic issues within the local system of care.

The review team consisted of representatives from DCF's Office of Child Welfare, the SunCoast and Southern regions, Children's Legal Services from the Northeast Region, Starting Point Behavioral Health Care (substance abuse provider in the Northeast Region), Manatee County Sheriff's Office Child Protective Investigations Division (Suncoast Region), Family Support Services of North Florida (community-based care provider in the Northeast Region) and the Child Protection Team medical director from the Southern Region (off-site).

The team completed a review of child abuse investigations, the case management case, and dependency court records. In addition, interviews were conducted with Department of Children and Families (DCF) Child Protective Investigators (CPI) from Palm Beach County, staff of the Broward Sheriff's Office (BSO) Child Protective Investigations Division, Children's Home Society (CHS) case management agency, Children's Legal Services (CLS), the Guardian ad Litem Program (GAL), and local substance abuse and domestic violence providers.

Practice Assessment

- The initial investigation was closed in June 2016, identifying the child as safe; however, the child should have been identified as "unsafe." A second report was received in September 2016, and the DCF CPI correctly identified present danger and "unsafe child," resulting in [redacted] being removed.

- The home-study completed by the BSO CPI on [redacted] for the placement of [redacted] contained inaccurate information, was incomplete, and did not provide a thorough assessment of the home environment.

- Investigative and case management activities were found to be compliance-based and did not include a thorough ongoing assessment of the family situation.

Organizational Assessment

- Leadership is very supportive of staff, as evidenced by collaboration and development of creative ideas, which have a positive impact on operational efficiency.
- In this case there was a lack of sharing of relevant information and reconciliation of conflicting information.
- The assigned Broward Sheriff's Office (BSO) CPI had a high case load, which impacted completion of the home study**.**

Service Array

- Circuit 15 has a full service array to meet the needs of the community and families served; however, the mother did not engage in available services.

Introduction

On March 2, 2017, the department received notification that 11-month-old [redacted] was removed from life support and officially pronounced deceased eight days after he was found to be in distress by his non-relative caregiver, 39-year-old [redacted].

On February 21, 2017, [redacted] found [redacted] breathing and whimpering in his crib with a blanket wrapped around his neck. As a result, 9-1-1 was called and [redacted] was transported to a local hospital. Due to the critical nature of his condition, [redacted] was transferred via helicopter to another hospital better equipped to meet his needs.

Over the course of the next several days, [redacted] condition continued to deteriorate and he was subsequently determined to have no brain activity. [redacted] mother, 22-year-old [redacted], elected to donate her son's organs; and following procurement on March 1, 2017, [redacted] was officially pronounced deceased. The cause of death is currently unknown and autopsy results are still pending.

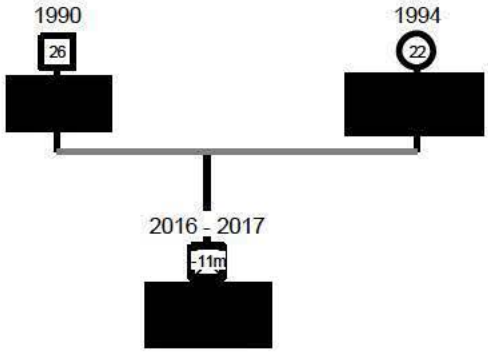
[redacted] was removed from his mother's custody in Palm Beach County in September 2016, due to her on-going substance use issues. Following an approved home study completed by the Broward County Sheriff's Office Child Protective Investigations Division, [redacted] was placed with [redacted] at her home in Broward County. Although she was initially identified as a relative, it was subsequently learned that [redacted] was not related to the child and, instead, was the girlfriend of the maternal uncle.

Because there was a verified prior report involving the family that occurred within 12 months of [redacted] death, DCF Secretary Mike Carroll deployed a Critical Incident Rapid Response Team (CIRRT) to Palm Beach County on March 6, 2017, to review the prior interventions with the family and to assess for any potential systemic issues within the local system-of-care.

This report represents the CIRRT's findings, the child welfare history, and a system of care review including practice assessment, organizational impact and array of available services.

Case Participants

Name	Age at Time of Incident	Relationship
[redacted]	11 months	Decedent
[redacted]	22 years	Mother
[redacted]	26 years	Putative father
[redacted]	39 years	Non-relative caregiver



Child Welfare Summary

Prior History on Child, [redacted]:

There were two previous reports involving [redacted] and his mother, [redacted]. The first report was received in Palm Beach County in April 2016, after [redacted] was born substance exposed and appeared to be experiencing withdrawals following his birth. [redacted] was subsequently discharged to his mother [redacted]. Although [redacted] was referred to out-patient drug treatment, she never engaged in treatment following investigative closure.

The second report was received in September 2016, which again noted concerns about [redacted] continued substance use and that she was doing so in the presence of [redacted]. Given the circumstances, [redacted] was removed from the home.

[redacted] was initially taken to Safe Place on September 20, 2016, while the home study was being completed in Broward County, and was placed with [redacted] on September 21, 2016. Safe Place is a 24-hour intake and assessment center in Palm Beach County and a resource for children initially removed from their homes. Prior to requesting the home study, the Palm Beach DCF CPI checked the Florida Abuse Hotline Information System (FAHIS) for abuse history; however, because [redacted] provided the wrong demographic information, the abuse history involving [redacted] was not immediately identified. Instead of [redacted] reported the name as [redacted]

Prior History on Caregiver, [redacted]

There are multiple reports involving [redacted], however, none since [redacted] had been placed in her home.

Approximately 11 reports were received between 1999 and 2014, [redacted] was removed from his mother's custody in Palm Beach County in September 2016, due to her on-going substance use issues. He was placed with [redacted] in Broward County following an approved home study completed by the Broward Sheriff's Office Child Protective Investigations Division. Although she was initially identified as a relative, it was subsequently learned that [redacted] is not related to the child and, instead, was the girlfriend of the maternal uncle.

System of Care Review

This review is designed to provide an assessment of the child welfare system's interactions with the [redacted] family and to identify issues that may have influenced the system's response and decision-making.

In this case, both strengths and opportunities for improvement were identified in the following areas. While opportunities to improve practice were identified, it should be noted that a direct correlation could not be made between the circumstances surrounding [redacted] death and the prior involvement with the family.

Practice Assessment

PURPOSE: This practice assessment examines whether the child welfare professionals' actions and decision making regarding the family were consistent with the department's policies and protocols. In this case, both strengths and opportunities for improvement were identified.

FINDING A: The initial investigation was closed in June 2016, identifying the child as safe; however, the child should have been identified as "unsafe." A second report was received in September 2016, and the DCF CPI correctly identified present danger and "unsafe child," resulting in [redacted] being removed.

[redacted] was born substance exposed [redacted], and had withdrawal symptoms requiring him to remain hospitalized for seven days. [redacted] drug screen taken at the time of delivery was positive for opiates, marijuana, and cocaine. Present danger was identified and [redacted] was released home with [redacted] identified as "safety managers" in the present danger plan responsible for keeping the child safe. [redacted] was added to the investigation as a caretaker and the investigation closed identifying the child was "safe." There was no follow up with [redacted] in the last five weeks of the investigation to ensure that the child was safe or verify that safety plan was effective to ensure child safety. At closure, [redacted] should have been identified "unsafe," resulting in the case being transferred to ongoing services as [redacted] had not demonstrated that she had the capacity to be protective of her child.

Three months after the first report was closed, a new abuse report was received on September 19, 2016, alleging [redacted] was using drugs around [redacted]. [redacted] danger was correctly identified and [redacted] was removed and placed in out-of-home care on September 20, 2016.

FINDING B: The home-study completed by the BSO CPI on [redacted] for the placement of [redacted] contained inaccurate information, was incomplete, and did not provide a thorough assessment of the home environment.

On the same day that [redacted] was removed, a request for an emergency home study was sent to Broward County. Prior to requesting the home study, the Palm Beach DCF CPI checked the Florida Abuse Hotline Information System (FAHIS) for abuse history; however, because [redacted] provided the wrong demographic information, the abuse history involving [redacted] was not immediately identified. Instead of [redacted] reported the name as [redacted], and claimed that [redacted] was her aunt.

While the correct demographic information was obtained when the home study was being completed by a Broward County BSO CPI on September 20, 2016, [redacted] was inappropriately identified as the maternal grandmother to the child, giving the impression of a closer relationship than that of a non-relative caregiver. [redacted] was actually the girlfriend of [redacted] uncle, [redacted], an individual who declined to be a caregiver for [redacted].

While there were no disqualifying charges, the history obtained through record checks was concerning. [redacted] had been identified as a caretaker in 11 abuse reports between 1999 and 2011, [redacted]. In addition, she had a criminal history that could have implications for child safety. Moreover, [redacted] had an extensive criminal history spanning from 1975 to 2014. The home study did not include an assessment of the criminal and prior abuse history or other concerns that needed further review with an overall assessment stating "there were no concerns with the caregiver's ability to care for the child."

[redacted]. The household composition was not assessed in its totality and [redacted] may have impacted the ability of [redacted] to care for another young child. The home study on [redacted] was approved by the BSO CPI on September 20, 2016, the BSO supervisor on September 21, 2016. At the shelter hearing held on September 21, 2016, the courts granted the shelter and authorized the placement with [redacted].

The Broward County BSO CPI uploaded the home study in FSFN, however, the signed hard copy of the home study and complete background checks were not initially sent to the DCF CPI or case managers. Documentation reflects that the courtesy ChildNet case manager in Broward County sent at least four emails requesting the home study, which was finally sent on November 3, 2016. Due to the delay in receiving the home study, live scan finger prints for all adults in the home was not requested until November 4, 2016.

The Broward County ChildNet case manager sent the completed background checks to the primary CHS case manager in Palm Beach County on November 22, 2016, and advised that although the home study was completed and approved by the Broward Sheriff's Office, they had concerns regarding the background checks and, as a result, a safety plan for the relatives may be needed. It was later determined that a safety plan would not be completed since the primary concern was [redacted] criminal history, and he was not the primary caretaker for the child. The home study was not officially filed with the courts until February 23, 2017, two days after [redacted] had been found unresponsive.

FINDING C: Investigative and case management activities were found to be compliance-based and did not include a thorough ongoing assessment of the family situation.

At initial contact with the family in September 2016, the DCF CPI identified present danger and the need for an out-of-home safety plan; however, the CPI did not fully explore the relationship to the possible caretaker identified or research other relatives. Information gathering stopped with the removal of the child.

The home study was completed on an emergency basis and prior to the shelter hearing the following day, with a focus of keeping the child out of licensed care. The home study was not fully evaluated or reviewed for content or concerns; and focused on the fact that there were no disqualifying criminal charges. The home study did not consider the dynamics of the household or fully assess the appropriateness of the placement for a young child, to include addressing

concerns that the caretaker appeared overwhelmed during a visit in December 2016. [redacted]. While the courtesy ChildNet case manager shared this information with the primary CHS case manager, there was no discussion about the appropriateness of [redacted] continued placement in [redacted] home.

The assessment completed by the ongoing CHS case manager did not fully address the family situation, the mother's protective capacities or behavioral changes needed for reunification, and was generated to meet a system requirement prior to completing the case plan. In this case, mediation was scheduled two weeks after the shelter hearing and the case manager needed to complete the case plan prior to the mediation. Throughout the life of the investigation and service case, there was a lack of attempts to engage the mother and to reconcile self-reported information such as her participation in substance abuse treatment. The CHS case manager communicated with [redacted] through text messages, in part because she would not provide an address.

Organizational Assessment

PURPOSE: This section examines the level of staffing, experience, caseload, training, and performance as potential factors in the management of this case.

FINDING A: Leadership is very supportive of staff, as evidenced by collaboration and development of creative ideas, which have a positive impact on operational efficiency.

In order to facilitate early engagement with families, the case management agency, CHS, has a court liaison who attends all shelter hearings. The case manager is assigned and will make contact the family within 48 hours of the shelter hearing, prior to the official case transfer from investigations.

Children's Legal Services (CLS) has a shelter intake unit with two attorneys that specifically handle the initial shelter hearings and are under the direct supervision of the managing attorney. Additionally, mediation dates are set at the shelter hearing, ensuring parents are aware of the date thus increasing participation. In this case, [redacted] was present at the shelter hearing and at mediation, agreed to identified case plan tasks; however, she did not show up for the arraignment hearing. CLS attorneys and case management units are aligned by court divisions which ensure continuity and relationship building in working judicial cases. Additionally, case managers typically only have hearings in one court room, minimizing conflicts of multiple hearings at the same time.

The lead agency, ChildNet, is responsible for providing pre-service training for all new case managers and CPIs in the circuit. Communication and relationship building between CPIs and case managers is enhanced through participating in joint training.

The Southern and Southeast regions have a standardized protocol in place for requests for out of county services, emergency home studies, and case transfer of hotline reports. The protocol outlines specific required actions and responsibilities, timeframes for response, and the conflict resolution process.

FINDING B: In this case there was a lack of sharing of relevant information and reconciliation of conflicting information.

Communication barriers and lack of information sharing was noted throughout process to approve the home study. Communication between the different agencies and counties involved

in the case occurred primarily via email, with no discussion about the accurate relationship of the caretaker to [redacted] or the prior abuse and background history concerns.

Case management services are initiated at the time of the shelter hearing and the meeting to transfer the case from the CPI to the case manager is held later, typically via a phone call between the CPI supervisor and case manager supervisor. In this case, the DCF CPI also participated; however, front line staff does not always attend. In this case, information regarding relationships or caretakers, other available relatives and the needs of the family was not fully shared or understood by all parties.

From the time the abuse report was received in September 2016, a phone number was available regarding the putative father, [redacted]; however, it was not shared amongst all parties involved in the case. For example, while the assessor completing the Comprehensive Behavioral Health Assessment (CBHA) and the Guardian ad Litem (GAL) were in contact with [redacted], who indicated a desire to see his child, neither the case manager nor CLS was aware of the father's location and were completing a diligent search in an effort to locate him.

FINDING C: The assigned Broward County BSO CPI had a high case load which impacted completion of the home study.

The Broward County BSO CPI assigned to complete the home study had a total of seven years of child welfare experience and a bachelor's degree in criminal justice. Despite this preparedness, the CPI's workload may have impacted her ability to complete a thorough home study as evidenced by the lack of assessment with regard to the information gathered and the fact that the relationship of the caregiver was completely inaccurate.

During the month of September 2016, she was carrying a caseload of 37 open reports and had received an additional 20 new investigations. The request to complete the home study for [redacted] placement was received on September 20, 2016, and was the third case assigned to the CPI on that day.

The completed home study was not sent to the Palm Beach County DCF CPI or primary CHS case manager until six weeks later.

Service Intervention/Array

PURPOSE: This section assesses the inventory of services within the child welfare system of care.

FINDING A: Circuit 15 has a full service array to meet the needs of the community and families served; however, the mother did not engage in available services.

For cases involving substance abuse, there is a dedicated Substance Abuse Call Center (SAC line) which is a 24-hour hotline available to CPIs and case managers. The SAC call center was created by converting the Family Intervention Services (FIS) positions into the countywide call center. The child welfare professional calls the 211 number from the field and provides basic client demographic information, answers a few questions and the client is provided with an appointment for a substance abuse assessment. The SAC responder enters a FIS note into the Florida Safe Family Network (FSFN) and, if needed, works with the CPI or case manager to arrange transportation for the client. Prior to implementing the SAC line, the engagement rate for substance abuse assessments was less than 35 percent and since implementation, percent of assessments completed has increased to more than 60 percent. The DCF CPI in the April 2016 investigation called the SAC line to schedule a substance abuse assessment for [redacted]

[redacted]. She attended the evaluation; however, never followed through with the recommended intensive day treatment at Gratitude House.

Safe Place is a 24-hour intake and assessment center in Palm Beach County and a resource for children initially removed from their home. Safe Place is an eight bed licensed facility which accepts children that have been removed from their home while they are waiting for a placement to be identified or approved. Typically, children remain in Safe Place for only a few hours while placement is located; however, in some cases there are extenuating circumstances where children remain over 24 hours. In this case, [redacted] went to Safe Place on September 20, 2016, while the home study was being completed in Broward County and was placed with [redacted] on September 21, 2016.

Early Steps provides evaluations for infants and toddlers with significant delays or a condition likely to result in a developmental delay. [redacted] was evaluated by Early Steps while placed in the home of [redacted].

Additional services available in the community include domestic violence and mental health providers. Safety Management Services are provided through Safety Management Action Resource Teams.

Immediate Operational Response

In order to ensure all reports are handled with the same sense of urgency, the Broward Sheriff's Office made changes to their protocol for assigning and handling cases from other counties and jurisdictions. Out of Town Inquiries, transfers, and requests for home studies were historically assigned to a CPI who was next up on rotation. The process has changed and effective March 11, 2017, all requests from other counties are assigned to one squad. (Refer to Attachment I)

Attachment I

Broward Sheriff's Office OTI Squad Protocol

Broward Sheriff's Office has one (1) specialized squad designed to handle all incoming OTI requests for Broward County. The squad is staffed with six (6) Child Protective Investigators Positions under one (1) supervisor so that there is a single point of contact for all requesting counties.
The OTI Unit handles the following cases:

I. **Concurrent Intake Assignment** – The Hotline assigns a child intake based upon the location of the household of focus, where the alleged maltreating parent resides, at the time the report is accepted. When a child is located in a different county from the household of focus then both a primary county & secondary county are assigned. All such intakes are coded immediate. All concurrent intakes will be assigned to the OTI Squad initially by the Analytical Unit except in after hour situations. In after hour situations the intake shall be referred to the on-call unit. The supervisor of the on-call unit may transfer the intake back to the OTI squad the following business day following all necessary documentation being completed; if such an after-hour commencement response led to identified present danger & implementation of safety actions accompanied to the present danger safety plan – then the manager shall do a 2nd tier consultation & approval prior to the concurrent intake being transferred to the OTI unit.

II. **Out of Town Inquires (OTI) and Transfers**- OTI requests shall be assigned to the OTI unit. The unit shall handle all such requests in full compliance to the Florida Administrative Code Rule, DCF CFOP & any FL DCF Regional OTI protocols in place.
    a. The county requesting the OTI will contact our analytical unit for all OTI requests. Once contacted the analytical unit confirms that the requesting county has the FSFN note entered outlining their requests. A subsequent email is sent to the requestor to provide written confirmation receipt of their request and to provide the name of the assigned CPI who will be handling their request and the assigned CPI/CPIS are both copied on the email. The email includes the contact information for the assigned CPI/CPIS and the FSFN unit profile for any transfer requests. The assigned CPI notifies the requesting county via email once the request is completed.

    b. Any emergency OTI request received after normal hours by the on-call supervisor will be handled in congruence to the necessity of the present emergency;

forwarding it back to the OTI unit the next business day through supervisor to supervisor staffing.

c. OTI requests for home studies within Florida for relative/non-relative emergency placements must be initiated as soon as possible but no later than four (4) hours. Home studies should be completed in its entirety and PIs should attach a copy of the caregiver's financial supporting documents and photos of the home. Each home study is uploaded into the FSFN at completion, emailed to the requestor, and a hard copy is sent by mail. Verbal approval or denial is conferred to the requestor at the completion of the home visit. This immediate verbal communication assists with the prevention of children going into license care. PIs will complete the formal request in writing to Childnet to complete the finger prints/live scans. PIs shall ensure that the caregivers sign the background screen release of information form. PIs will confirm receipt of request to Childent via telephone with Vilma Moya (954) 414-6000 ext. 3605.
d. OTI requests for initial child victim interviews will be commenced within four (4) hours from the time of the OTI request.
e. OTI requests for follow-up (i.e., not initial contacts) victim interviews, sibling, adult family members and all other collateral contact requests must be commenced within 24 hours unless the circumstances warrant an immediate response and completed within 5 days from the time of the OTI request. Information obtained is documented into a chrono note as well as the respected domain in the FFA. For example, if the request is to interview a child, information obtained would be documented into the child functioning domain
f. Requests for local criminal history background checks must be submitted to law enforcement within 72 hours from the time of the OTI requests.
g. Transfers requests are responded to within 24 hours unless there is an immediate response. All transfer requests are reviewed by the unit CPIS to determine if the transfer will be accepted. The transfer is not completed until verification that the AP resides in Broward County. The investigation is reviewed to ensure the PDA has been completed, the victim child/ren has been seen, notes are entered into FSFN, the FFA launched if applicable, and initial supervisory consultation has been completed. If present danger has been found, a phone conference will be completed with all parties to discuss the information prior to case transfer to continue the established safety plan. All requests must be made in FSFN under "Case Transfer Request" to Analytical Supervisor Tashara Gay 100BSO.

III. **Out-of-State Inquiries –** Both Florida OTI & out-of-state OTI requests shall be assigned to the OTI unit. The unit shall handle all such requests in full compliance to the Florida Administrative Code Rule, DCF CFOP & any FL DCF Regional OTI protocols in place.

a. Any emergency OTI request received after normal hours by the on-call supervisor will be handled in congruence to the necessity of the present emergency; forwarding it back to the OTI unit the next business day through supervisor to supervisor staffing.
b. Out-of-state OTI requests from child protective entities comparable to CPIS will be accepted after verification of authenticity of agency, preferably with an e-mail, facsimile request on agency letterhead.
    i. For purposes of compliance to official government accountability for CPIS actions & related record documentation the Analytical Unit or OTI unit Supervisor will create a FSFN service request recording all out-of-state requests.

ii. The FSFN outcome of a service request will generate a FSFN intake # & case that will be used for data entry.
iii. Out-of-state OTI requests will be submitted at closure to closed records.

c. Out-of-state placement requests are required to follow the regulations of the Interstate Compact on the Placement of Children (ICPC) and are not eligible for the OTI process.
d. Requests for local criminal history background checks must be submitted to law enforcement within 72 hours from the time of the OTI requests.

IV. **Abandon Cases/Case Load Reduction:** The OTI unit assists with abandoned cases from employees that are no longer with the agency and as needed to assist active employees with caseload reductions. The division goal is 15 cases or less for each Child Protective Investigator.

Scheduling:

The CPI's within the squad will be scheduled sufficiently as to provide coverage seven (7) business days a week, with the exception of holidays. The scheduled hours of the squad CPI's shall be positioned in such a fashion as to ensure basic coverage exists when coworkers are on leave of absence. CPI's working on Saturday and Sunday will only receive OTI cases. On weekends (Saturday and Sunday) the CPIs will only receive OTI requests and concurrent cases with secondary assignment.
Recommended coverage (6 CPI's & 1 supervisor):

PIs schedule:

Monday - Friday:	09:00 AM to 05:00 PM	- 5 CPI's
Monday - Friday:	11:00 AM to 07:00 PM	- 1 CPI
Saturday-Sunday	09:00 AM to 05:00 PM	- 1 CPI's